

**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, DOB: \_\_\_\_\_ living at \_\_\_\_\_

give permission for Lisa T. Ziobro, M.A., LMFT to release to and obtain from the persons / entities listed below, information related to the provision of services for \_\_\_ me, \_\_\_ for my minor child

Name of child: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>OBTAIN FROM / RELEASE TO (only one provider/school/agency per form)</b> (check only one box) <input type="checkbox"/> Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Mental Health Provider <input type="checkbox"/> School <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> DSS <input type="checkbox"/> Probation <input type="checkbox"/> legal/judicial <input type="checkbox"/> other _____
Name: Address: Phone:

The purpose for such disclosure:

- \_\_\_ Coordination of treatment between providers
- \_\_\_ Communication between providers
- \_\_\_ Verification of treatment
- \_\_\_ Facilitation of a referral
- \_\_\_ Collection of assessment information
- \_\_\_ Facilitation of an evaluation
- \_\_\_ Enable payment of services with insurance or contract payor
- \_\_\_ Enable judges, attorneys, probation or parole staff, to take legal actions on my behalf

Information to be shared (r=release; o=obtain):

- |                              |                              |
|------------------------------|------------------------------|
| ___ medical information/exam | ___ psychological evaluation |
| ___ school information       | ___ alcohol/drug evaluation  |
| ___ status in treatment      | ___ recommendations          |
| ___ treatment goals          | ___ discharge plan/ summary  |
| ___ history of services      | ___ court mandated plan      |
| ___ client history           | ___ probation history        |
| ___ other _____              |                              |
| _____                        |                              |
| _____                        |                              |

Consent will expire:

- \_\_\_ upon completion of services
- \_\_\_ 90 days following completion of services
- \_\_\_ on this date \_\_\_\_\_

You have the right:

- to not sign this form
- to revoke your permission at any time after signing this form. To revoke your consent at any time, please put your request in writing to me at: Lisa Ziobro, P.O. Box 282, Homer, NY 13077.
- to ask for copies of all **AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION** forms signed by you
- to modify this form or the information sharing you authorize at any time

Your privacy regarding HIV-related information is protected under NYS Public Health Law Article 27-F. Your privacy regarding substance abuse related concerns is protected under Federal Regulations (42 CFR Part 2).

Your signature on this form means that you authorize me to release and obtain information described above. It also means that you understand that this information may be re-released by the recipients if they are not required by law to protect it, or if they do not abide by the same privacy protection standards that I do.

By my signature, I acknowledge that I have read this form and that all of my questions about this form have been answered. I understand what I am signing and agree with it.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent, guardian or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date